Virginia Department of Medical Assistance Services

RECIPIENT CHOICE - Institutional Care or Waiver Services Form

Individual Being Screened: _____ Medicaid ID#: _____

I.	**SCREENING TEAM DETERMINATION:** Refer to Appendix B, Pre-Admission Screening Manual. Note: "Individual" refers to the individual being screened and, if applicable, the family member, parent, legal guardian, or authorized representative.				
	A.	**Individual Meets Nursing Facility Criteria** (Functional Dependency Level and Medical/Nursing Needs Present):			
		☐ YES *(must be checked to authorize Nursing Facility Placement)*		☐ NO	
		☐ Application for the individual to a nursing facility has been made and accepted. Date application was made:			
		Facility:		Contact:	
	B.	☐ Deterioration in individual's health care condition or changes in available supports prevents former care arrangements from meeting needs.			
		Describe:			
		☐ Evidence is available that demonstrates individual's medical and nursing needs are not being met (e.g., recent physician's documentation of instability, findings from medical/social service agencies).			
		Describe:			
	C.	**Individual has selected (*please select only one option*):**			
		☐ Nursing Facility Services; OR			
		☐ Elderly or Disabled with Consumer Direction Waiver Services; OR			
		☐ HIV/AIDS Waiver Services; OR			
		☐ Program for the All-Inclusive Care of the Elderly (PACE) (if available in service area); OR			
		☐ Alzheimer's Assisted Living Waiver; OR			
		☐ Technology-Assisted Waiver (for adults and children); OR			
		☐ Elderly Case Management Services (if available in service area).			
		☐ Managed Care Organizations (MCO) choices if available in service area – For a comparison chart, please contact the Enrollment Broker			

Complete Sections II and III ONLY if Nursing Facility Criteria and Risk of Waiver Services Placement Are Met

II.	**CHOICE AND PAYMENT RESPONSIBILITY**
	Medicaid will pay for someone to come into your home to care for you as long as in-home services will safely meet your needs and is less costly than nursing facility care. The screening team does not authorize the amount of services or times of day or days of week on which services will be provided. You may choose to receive in-home services if there is an available provider in your area, and you have additional support from family and/or friends or are able to maintain health, safety and welfare without additional help when in-home services are not being provided.
	To stay at home, help in the following areas is needed *(check all that apply):* ☐ Respite ☐ Housekeeping ☐ Meal Preparation ☐ Shopping ☐ Laundry ☐ Supervision *(Attach DMAS-100)* ☐ Personal Care ☐ ADLS ☐ PERS *(Attach DMAS-100A)* ☐ Transportation ☐ Skilled Nursing Needs/Private Duty Nursing

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III.	**DOCUMENTATION OF INDIVIDUAL CHOICE (***The following has been presented and discussed with the individual:)*	
	☐	The findings and results of the individual's evaluation and needs.
	☐	A choice between Institutional Care (nursing facility) and the appropriate Home- and Community-Care Based Waiver, PACE (if available in service area) or MCO (if available in service area).
	☐	The individual understands when a diagnosis of a mental illness, mental retardation/intellectual disabilities or related condition exists a secondary screening is required to determine if additional services are necessary. Services can not start until the completion of the secondary assessment. For NF = Level II Screening. For Waiver = 101B Screening
	☐	The individual's right to a fair hearing and the appeal process.
	☐	The individual's right to choice of provider(s). If known, insert provider name here: _____
	☐	The individual's right to choice of service(s).
	☐	The individual's potential to have a patient pay amount, based on his or her income, regardless of the amount of institutional or community-based care received.
	☐	The individual's understands that, by using Consumer-Directed Services, he or she bears the responsibilities associated with employing his or her own personal attendants. *NOTE: DMAS is not the employer for Consumer-Directed Services.*
	☐	The individual's (or authorized representative's) consent to exchange information with the Department of Medical Assistance Services (DMAS) by signing and dating this form. This consent will remain in effect until revoked by the individual (or authorized representative) in writing.

IV. SIGNATURES

The above information has been discussed with me. I understand that the provider will develop a Plan of Care with my assistance based on my needs and my available support. Provider staff is responsible to provide continuous and reliable care. I understand that when there is a lapse in service I am responsible to provide back-up support.

Individual's Signature	Date	Screener's Signature	Date

Family Member, Parent, Legal Guardian, or Authorized Representative	Date	Indicate Applicable Designation

Instructions for Completing the DMAS-97

Complete this form when authorizing nursing facility or home- and community-based care services.

Section I: Screening Determination

Item A must be checked "YES" or "NO" to indicate if nursing facility placement is authorized.

Item A or at least one of the conditions in B must be completed if authorizing home-and community-based care services.

Item C must be completed to document the individual's choice of institutional services versus waiver services.

Section II: Community-Based Care Choice and Payment Responsibility

Section II must be completed in its entirety if community-based care criteria are met, and the individual chooses home- and community-based care services.

The screener must check services that the individual will need in order to remain at home.

The screening committee must explain to the individual that the screening committee does not authorize the amount of services or times of day or days of week on which services will be provided. The provider agency will make that decision with the individual based on their needs and wishes identified during the screening.

Section III: Documentation of Individual Choice

Section III must be completed in its entirety regardless of whether institutional care or home- and community-based care is chosen by the individual. Please be sure that each item is discussed with the individual.

Section IV: Signatures

Review the statement of understanding with the individual and ensure that all applicable signatures are obtained.

Please remember to obtain the individual's signature that assures the individual was given a choice of providers and was advised of his or her possible patient pay responsibility.

Please remember to obtain the individual's family member, parent, legal guardian or authorized representative's signature and indicate the applicable designation for the person who is signing.